North Carolina Child and Family Leadership Council

January 2008 Report To The

Office of the Governor

Joint Appropriations Committees and Subcommittees on Education

Joint Appropriations Committees and Subcommittees on Justice and Public Safety

Joint Appropriations Committees and Subcommittees on Health and Human Services

Fiscal Research Division of the Legislative Services Office

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December 31, 2007

Pursuant to Session Law 2007-323, Section 10.9, the North Carolina Child and Family Leadership Council submits its January 2008 Report to the Office of the Governor; the Joint Appropriations Committees and Subcommittees on Education; the Joint Appropriations Committees and Subcommittees on Justice and Public Safety; the Joint Appropriations Committees and Subcommittees on Health and Human Services and the Fiscal Research Division of the Legislative Services Office.

Respectfully Submitted,

The North Carolina Child and Family Leadership Council

Executive Summary

This report presents data and findings from North Carolina's School based Child and Family Support Team (CFST) Initiative from July 1, 2007 through December 31, 2007. This is the fourth such report prepared by the Child and Family Leadership Council, which fulfills its legislative mandate to submit a report by January 1, 2008.

This report recognizes the connection between student health and wellness and academic achievement. Governor Michael F. Easley wants to help "every child in every corner of every county in North Carolina" have an opportunity to succeed in school by establishing a system to serve students facing negative health, mental health, social, developmental, legal, or academic conditions in their lives. Included in the report is a brief description of the legislation enacted by the North Carolina General Assembly authorizing the implementation of the CFST, the selection of the school systems and schools, its purpose, core principles and values, services design and operation, and a description of data collected by participating agencies during 2006-2007 school year. Some of the data was collected by Duke University's Center for Child and Family Policy (CCFP) from sources such as a web based case management system, and surveys of CFST nurses and social workers, principals, county CFST coordinators, as well as from a sample of parents and students.

During the 2006 - 2007 the 21 school systems participating in the CFST provided services to more than 7,600 students in 101 schools. Student demographics, reasons for referral, service needs, services provided and barriers to services varied greatly from school system to school system and between individual schools within any one school system. A description of those issues, as well as other points of interest is included in the report. The case management data presented in the report will represent what was entered into the system concerning students served through July 31, 2007.

INTRODUCTION, LEGISLATION AND HISTORICAL CONTEXT

It is recognized that meeting the basic needs of students by ensuring that they are safe, healthy, and ready to learn is central to improving their academic performance. A 2005 study conducted by the California Department of Education researched the connection between health variables, risk behaviors, supportive school environments and the academic success of students. It concluded that there is "key and convincing research that a school's focus on all the elements of health and resilience not only is a sound and necessary strategy to achieve academic goals, but also is essential to academic success."[1]

2006 research conducted by the Center for Social Organization of Schools at Johns Hopkins University[2] found:

- 8th grade factors gave students who attended school less than 80% of the time in 8th grade (that is, missing at least 5 weeks of school), and received a failing final grade in mathematics and/or English during 8th grade at least a 75% probability of dropping out of school.[3]
- 9th graders who attended less than 70% of the time during 9th grade, earned fewer than 2 credits during 9th grade, or were not promoted to 10th grade on time; and were not identified as an at-risk 8th grader had a 75% probability of dropping out of school.
- 90% of the students who had a juvenile justice placement during their high school years ultimately dropped out.
- About 70% of the students who had a substantiated case of abuse or neglect during the high school years, had a foster care placement, or who gave birth within four years of starting high school dropped out of school.

The State Board of Education has made making North Carolina's public school students "healthy and responsible" a key goal in its mission "that every public school student will graduate from high school, globally competitive for work and postsecondary education and prepared for life in the 21st Century."[4]

This is also supported by the North Carolina Department of Public Instruction on its NC Healthy Schools web site.

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[1] "Getting Results: Update 5, Student Health, Supportive Schools, and Academic Success", California Department of Education, Sacramento CA, 2005, page 1. It is available on-line at http://www.gettingresults.org/c/@i9xna6RsPnSQI/Pages/downloads.html.

[2] "Unfulfilled Promise: The Dimensions and Characteristics of Philadelphia's Dropout Crisis, 2000–2005", Copyright 2006, Philadelphia Youth Network, The Johns Hopkins University and the University of Pennsylvania. Available on line at: http://www.projectuturn.net/downloads/pdf/Unfulfilled_Promise_Project_U-turn.pdf.

[3] Of those 8th graders who attended school less than 80% of the time, 78% became high school dropouts. Of those 8th graders who failed mathematics and/or English, 77% dropped out of high school. Importantly, gender, race, age, and test scores did not have the strong predictive power of attendance and course failure.

[4] http://www.ncpublicschools.org/state_board/AboutSBE.html

"The health of young people is directly tied to academic achievement and their potential for school success and overall quality of life. The schools alone cannot solve or prevent health related problems. However, the schools' ability to have a positive impact on students' health behavior and academic gains is enhanced with the help of community resources." [5]

Governor Easley's commitment to meeting the needs of children in North Carolina was demonstrated through the implementation of his Child and Family Support Team Initiative. At his request and through his leadership, the Departments of Health and Human Services and Public Instruction collaborated to develop a program that established school-based teams (a certified school nurse and a licensed school social worker) to work with identified liaisons at local mental health agencies and departments of social services, as well as staff members from local health departments and the Juvenile Courts to ensure students and families receive the services they need to support their success in school.

The CFST Initiative was originally authorized and funded in 2005 session of the North Carolina General Assembly through the enactment of Session Law 2005-276, Senate Bill 622, "2005 Appropriations Act". In its 2006 session, the General Assembly continued to support the Initiative through the allocation of recurring state funding to local mental health and social services agencies to hire the legislatively required care coordinators and facilitators. This was in the June 30, 2006 "Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets." Through Session Law 2007-323, "2007 Appropriations Act" the General Assembly continued its authorization and funding for the Initiative.[6]

In January 2006, 21 of North Carolina's 115 public school systems were selected as pilots to participate in the Initiative[7]. The participating sites were selected based on the following criteria:

- Identified needs of children and families in selected schools;
- Demonstrated commitment of the school system and their health, mental health and social service partners to work together to address the needs of children and families
- Geographic diversity statewide; and
- Readiness to implement at the community and school level.

[5] http://www.nchealthyschools.org/schoolhealthadvisorycouncil

[6] For greater detail concerning the legislative history of the CFST, the reader may access the legislation by on the General Assembly's web site. The 2005 legislation is at http://www.ncleg.net/Sessions/2005/Bills/Senate/HTML/S622v9.html. The 2006 is at http://www.ncleg.net/sessions/2005/budget/2006/budgetreport6-30.pdf. The 2007 is at http://www.ncleg.net/Sessions/2007/Bills/House/PDF/H1473v10.pdf.

[7] See Attachment 1: "CFST Map" and Attachment 2: "List of Participating Local Education Agencies and Schools" for the selected school systems and schools.

While each school system has its strengths, all 21 of the selected sites share the fact that certain conditions place them among the highest need school systems in North Carolina. Some of these conditions include:

- High number of children receiving free or reduced lunch
- High unemployment caused by the closing of local industry
- Rural nature of the community makes it difficult to recruit and retain staff in all public serving agencies
- A lack of public transportation services
- A lack of health and/or emergency mental health/substance abuse services
- A growing number of single-parent one-income families,
- A lack of low-income housing
- A growing number of students living outside of their parents' homes
- A growing number of immigrant families experiencing difficulty in various areas, and
- A lack of parental trust and involvement in the school system and other public agencies

Each selected CFST site has an average of 5 schools. The minimum number of teams in any one school system is 2 (serving in 3 Hyde County Schools) with several having 6 or 7 teams. The student population of the 101 schools is approximately 64,000 students.[8] Of the 101 schools, Person High School's student population of 1739 is the highest while Hoffman Elementary School in Richmond County has the lowest with 138 students. The average number of students in the 101 schools is 623. Twenty-six schools have student populations over 750, which places them over the ratio of school nurses to students recommended by the National Association of School Nurses and the National Center for Disease Control.

PURPOSE AND MISSION

A review of the authorizing legislation shows that intent of the Initiative is two-fold:

- To create a program of student support designed to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement due to the physical, social, legal, emotional, and developmental factors that negatively affect their academic performance.
- For the Department of Health and Human Services, the Department of Public Instruction, the State Board of Education, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts, and other State agencies that provide services for children to share responsibility and

[8] Based upon information as reported on NC DPI's "NC School Report Card" web site. It can be accessed at http://www.ncschoolreportcard.org/src/.

accountability for improving academic and well-being outcomes for at risk children and their families.

The mission of the CFST Initiative is for participating child serving State and local agencies to collaborate and provide individualized, strengths based, family centered support services at such a level that every child in their communities will be given every opportunity to succeed academically.

PROGRAM PRINCIPLES AND VALUES

The Initiative shares many of the family-centered principles and values utilized by the Division of Social Services' Multiple Response System child welfare reform (MRS), the Division of Mental Health / Developmental Disabilities / Substance Abuse Services' Child and Family Mental Health Services (CFMHS), the Department of Juvenile Justice and Delinquency Prevention's Juvenile Crime Prevention Council Program and the North Carolina Healthy Schools Program (a Department of Public Instruction and Department of Health and Human Services collaborative effort). The CFST also shares common principles and values with several specific programs in the Department of Public Instruction. They include Homeless Services, Positive Behavioral Supports, Safe and Drug Free Schools, Student Support Services and Dropout Prevention and Intervention.

While each may have principles unique to its specific mission or legislative responsibility, the following is summary of those shared with the Initiative:

- The need to engage and involve parents and their natural support systems.
- The need to strengthen interagency collaboration and accountability
- The need for children to remain in their own families, communities and schools if possible.
- The provision of culturally competent, individualized, strengths based services.
- The delivery of services in the most cost effective natural setting possible.

The Initiative shares other key principles specifically with the CFMHS program and MRS child welfare system reform[9] mentioned above. They include:

- Use of the system of care principle "one child, one team, one plan"
- Services are specified, delivered, and monitored through a unified, outcome-oriented and evaluation-based Child and Family Plan that bases its strategies on the family's strengths.

[9] More information on the MRS may be found at http://www.dhhs.state.nc.us/dss/mrs/index.htm#what. Information about the CFMHS may be found at http://www.dhhs.state.nc.us/mhddsas/childandfamily/index-new.htm.

- The Child and Family Plans are written by Child and Family Teams during their meetings.

The utilization and sharing of these core principles helps to ensure that:

- Each child and family's unique needs are met
- Services are accessible to families and offered at convenient times and locations;
- Checks and balances exists to ensure services are working and there are ways to make changes when they are not working; and
- The outcomes of delivered services are evaluated to ensure they succeeded in meeting the identified needs.[10]

PROGRAM DESIGN

The Initiative is based on system of care principles which increase interagency collaboration to best meet the needs of children and families. This is recommended practice across most agencies serving children[11].

At the county-system level this interagency collaboration is achieved and managed through the establishment of a local advisory committee. The authorizing legislation sets its membership and requires that each school system establish one to "monitor and support the successful implementation of the Initiative".[12] It is the intent of the legislation that the heads of the local child serving agencies engage in dialogue and collaboration to the level that organizational barriers to services are eliminated and services are being provided in as efficient manner as possible.

At each school, a nurse-social worker team is charged with identifying students at risk of academic failure or out of home placement, conducting holistic, strengths based assessments to ascertain the student's primary unmet need, and collaborating with the family and other agencies to meet the identified needs. This collaboration is accomplished through the development of a strong infrastructure of interagency collaboration based on a child and family team model, in this case called Child and Family Support Team. These teams are centered on the families and include their natural supports and representatives from social services, mental health, the courts, public health and other child serving agencies.[13]

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[10] Revised from the "North Carolina System of Care Resource Book, Tools from NC FACES, Part 1: C&F Teams", page 6.

[11] Hornberger, S., Gardner, S. l., Young, N. K., Gannon, N., P., & Osher, T. (2005). Improving the quality of care for the most vulnerable children, youth, and their families. *Finding Consensus.* Washington, DC: CWLA Press. Retrieved May 8, 2007, from http://www.cwla.org/programs/bhd/qualityofcarefront.pdf)

[12] 2007 Appropriations Act, Section 10.9.(a)(5)

[13] Refer to Attachment 3, "North Carolina School Based Child and Family Support Team Interagency Connections" for specific information concerning the various state agencies connected to the CFST Initiative.

Local management entities and county departments of social services are required to appoint specific staff members to support students and families by working closely with the school nurses and social workers. It is intended for the mental health care coordinators and social services facilitators to work very closely with the school nurses and social workers to make sure students and families receive appropriate services as quickly as possible. Their primary responsibility is to ensure that the complexity of their agencies does not present as a barrier to the students and families benefiting from the myriad of services available to them. They also serve as an information and referral resource regarding their agencies, and work to connect families and students to services offered by their agencies.

State funding was allocated in 2006 to provide for 18 care coordinator positions in the 13 LMEs connected to the Initiative. Twelve county departments of social services (Anson, Bertie, Duplin, Greene, Halifax, Hoke, Hyde, McDowell, Martin, Nash, Pamlico and Vance) were allocated funding to hire facilitators to support the Initiative in their counties. The remaining 10 have appointed facilitators as required by the legislation but receive no state funding for the positions.

STUDENTS SERVED

According to data entered into the CFST case management system during the 2006 – 2007 school year 7,617 students came to the attention of the nurse-social worker teams through an established referral process. According to the data the most often cited reasons for referral included the following[14]:

- Excessive absences (28% of the referrals)
- Health concerns (28% of the referrals)
- Inappropriate behavior (25% of the referrals)
- Mental health concerns (22% of the referrals)
- Held back to repeat a grade 1 or more years (20% of the referrals)

The referral data also may be used to interpret what individual school systems and schools may be using as criteria for defining an at- risk student. This may be gleaned from what is named as the most frequent reason students were referred to the CFST. For example:

- In Martin 52% of the students referred had been retained 1 or more years
- In both Caldwell and Nash/Rocky Mount 54% of the students referred had health problems
- In Greene 48% of the students referred had excessive absences

[14] The reasons for referral are duplicated counts in that someone making a referral may cite any number of reasons for their concern.

- In Hoke 49% of the students referred had mental health problems
- In Hyde 45% of the students referred had inappropriate behavior

The tables below provide data concerning the number of students referred by county as well as aggregate demographic information. The data illustrates the differences in, and diversity of the students served by the nurse-social worker teams. The students served in the Initiative vary by race, ethnicity, age and grade. This multiplicity emphasizes how important it is that the nurses and social workers be competent in areas concerning developmental stages of students and cultural diversity.

It should be noted that both Hyde and Bertie school systems were unsuccessful in their efforts to recruit and retain staff (especially nurses), and that has had a direct impact on the level of services they were able to provide and is reflected in their data.

Table 1: Students By County

County	# Students	County	# Students
Alamance	739	Martin	296
Anson	376	McDowell	222
Bertie	30	Nash- Rocky Mount	661
Caldwell	376		
Duplin	444	Pamlico	186
Durham	265	Person	306
Forsyth	594	Richmond	204
Greene	192	Scotland	760
Halifax	235	Swain	265
Hoke	147	Vance	520
Hyde	26	Wayne	773
Total: 7,617			

Table 2: Students By Race

	Number	Percent
African American	3,976	52%
Asian	36	0%
White	2,486	33%
Native American	281	4%
Other	585	8%
More than one	118	2%
Race Missing	135	2%

Table 3: Students by Ethnicity

	Number	Percent
Hispanic	826	11%
Non-Hispanic	6,478	85%
Missing	313	4%

Table 4: Students by Grade					
Grade	**# Students**	**Percent**	**Grade**	**# Students**	**Percent**
pre-K	65	1%	6th	833	11%
K	513	7%	7th	812	11%
1st	584	8%	8th	816	11%
2nd	502	7%	9th	740	10%
3rd	618	8%	10th	396	5%
4th	601	8%	11th	321	4%
5th	540	7%	12th	225	3%
			Grade Missing	51	1%

Table 5: Students by Special Education Status		
	Number	**Percent**
Not in Special Education	4,856	64%
Gifted	72	1%
Behaviorally emotionally handicapped	254	3%
Hearing Impaired	29	0%
Educable mentally handicapped	298	4%
Deaf-blind	1	0%
Visually Impaired	27	0%
Other Health Impaired	245	3%
Orthopedically impaired	12	0%
Traumatic Brain Injured	6	0%
Severe-profound mentally disabled	15	0%
Multi-handicapped	18	0%
Speech-language impaired	93	1%
Trainable mentally handicapped	27	0%
Specific learning disabled	317	4%
Autistic	35	0%
Developmentally Delayed	117	2%
Missing	1,195	16%

Anyone may refer students to the CFST. This is accomplished through the use of a standardized referral form developed with the input of the nurses, social workers, and central office staff members in the participating school systems. The forms and instructions for their use are distributed by the nurse-social worker teams. The teams also are responsible for providing information concerning CFST services to those who may make referrals. Anyone wishing to refer a student completes and submits it to the nurse-social worker team serving the particular student. According to data entered into the CFST case management system, 8,728 such referrals were submitted to the nurse-social worker teams. The table below illustrates these referrals by school system.

Table 6: Referrals By County			
County	**# Referrals**	**County**	**# Referrals**
Alamance	848	Martin	322
Anson	544	McDowell	244
Bertie	30	Nash- Rocky Mount	782
Caldwell	455		
Duplin	511	Pamlico	190
Durham	291	Person	324
Forsyth	672	Richmond	216
Greene	201	Scotland	927
Halifax	259	Swain	276
Hoke	159	Vance	564
Hyde	29	Wayne	884

Once a student comes to the attention of the nurse-social worker team an investigation of his or her status in school is conducted to ascertain whether or not CFST services would be appropriate. This includes conducting a review of appropriate school records as well as interviewing teachers, administrators, and the students (as appropriate for age and the situation). The purpose of this activity is to ascertain two things:

- If the student is at risk of school failure or out of home placement
- If the student is currently receiving appropriate services to meet his or her needs.

If the student is determined to be at risk and not receiving appropriate services, the CFST team makes contact with the student's family to explain their services and offer assistance. In some cases the situation is resolved through actions resulting from this initial conversation. It may be that the student's need is quickly resolved by making a referral to services already present in the school (such as a psychological assessment or exceptional children's referral), or readily accessed in the community (such as help with getting glasses or a prescription filled). In most cases, however, this process involves working with the family to conduct an in-depth assessment and assemble a child and family team to identify and meet the student's or family's needs.

The areas of need most often cited in the case management system are as follows:

- Educational needs (27% of the time)
- Emotional/Mental Health needs (26% of the time)
- Physical Health needs (24% of the time)

The team's membership is decided by the family with the help of the CFST nurses and social workers. It always includes the family, the student (if age and developmentally appropriate) and the CFST school staff. Others join the team as needed and chosen by the family, with the assistance of the nurse-social worker teams. These may include staff members from other child serving agencies (mental health, social services, public health,

juvenile court, etc.) as well as anyone who is important in the life of the child and family and who knows their strengths and needs and can lend support.

The CFST model of services places the family at the center of all planning, delivery and monitoring of services. All services are to be planned during Child and Family Team meetings, and the students and their families have the prominent role in those meetings. Ideally there should be more family members and members of their support system present at CFST meetings than professional staff. No meeting can be held, and no plan for services made, without the family being present and participating in the meeting. The meetings should be scheduled at times and in places convenient to the family, and should often occur off the school campus and outside school hours. Other school based services often require families be notified and offered the opportunity to be involved in planning for services, frequently have more professionals involved in meetings with families than their informal supports, and frequently occur in the school buildings during the normal school day.

According to the case management system there were 5,819 CFST meetings held last year. Data concerning who attends the meetings and where they are held is currently being collected and analyzed by Duke University and will be included in future reports.

The CFST team works collaboratively to identify student and family strengths as well as specific needs. By building upon the identified strengths, the team develops a set of service goals and a plan for achieving them. The team decides which agency will function as the "lead agency" and therefore performs the case management aspects of the services. Some key functions of the lead agency are to:

- Schedule, arrange and facilitate the Child and Family Support Team meetings.
- Build a trusting relationship with the student and family to secure their engagement and involvement in the process.
- Ensure that the student and family remain central to any decisions made about them, and providing the student or family with sufficient information to empower them to make their own decisions.
- Use the CFST process and team meetings to ensure that needed services are being provided and case progress is monitored.

Agencies taking the role as "lead" for the CFST during the last year were as follows:

- Schools (73%)
- Mental Health (11%)
- Social Services (7%)
- Public Health (2%)
- Juvenile Justice (2%)
- Data Missing (5%)

Participants at the child and family team meetings jointly develop and sign service plans as a means of increasing ownership and accountability of everyone at the table. These plans are strengths based and individualized to address the unique circumstances faced by the student and family. They document identified strengths as well as specific needs, services, who will take the lead in providing specific services, time frames for completion and a crisis plan (if necessary). This model of team decision making and inter-agency coordination of services is designed to reduce many barriers to the student and family receiving needed services (such as who to call, transportation, health insurance and cost issues, language barriers, etc.).

The services identified by the teams (and listed on the service plans) includes the following:

- Medical/Physician services (18.5% of the time)
- Support for parents (12.2% of the time)
- Referrals to "other community agencies" (10.9% of the time)
- Counseling services (10.6% of the time)

As noted above, the CFST process also identifies any issues that may have presented barriers to the provision of services. The most significant barriers identified this past year are as follows:

- Parents refused services (16%)
- Cost (12%)
- Transportation (10%)
- Scheduling problems (9%)
- Student refused services (8%)

Given that participant (parent and student) refusal of services (parent or student) was noted to be the barrier in about 25% of the cases, ensuring the CFST nurses and social workers enhance their capacity to engage and partner with them continues to be a programmatic priority.

The school based CFST team stays actively involved with the family until such a time as the service need is met and is no longer causing the student to be at risk, or the case is closed for another reason.

Since the needs and negative circumstances of students and families do not end during the summer, each school system is also responsible for developing methods to ensure that the students' and families' needs are met when school is not in session. They were also required to report those strategies to the CFST Program Coordinator prior to the end of the 2006-2007 school year. Some of the strategies used this past summer included:

- CFST nurses and social workers maintaining 12-month employment

- Maintaining an on-call system for all CFST nurses and social workers (reached by cell phones, pagers and through the 12-month administrative school staff)
- Summer coverage provided by 12-month lead nurses and social workers (who have received all the training and attended all required CFST meetings)
- CFST nurse-social worker teams rotating coverage throughout the summer
- One 12-month nurse-social worker team providing coverage for all students over the summer

As a component of its evaluation, Duke University is collecting and analyzing information entered into the case management system concerning the services provided through this past summer. A summary of findings on this issue will be included in future legislative reports.

PROGRAM IMPLEMENATION

With the close of the 2006-2007 school year the 21 school systems completed their first full year of implementation of the Initiative. It required nurses and social workers to get out of what school nursing and social work had become known for, and learn new ways of meeting the complex needs of their students. The authorizing legislation defined their roles and focused their responsibilities in the schools. Their role is to work as a team, with community partners to identify the most at risk students and meet their needs. Their responsibility is to serve those students who would fail academically or face instability in their homes without specialized, targeted interventions.

They were placed in school settings that had few or no other nursing or social work services. As a result, many of them faced constant pressure to provide both traditional and CFST services in their schools. Traditional duties that have the potential to conflict with those required of the Initiative may include such things as functioning as the attendance counselors, testing proctors, lunch room and bus line monitors, teaching classes to free planning time for teachers and staffing the health clinics during school hours. Being in the building every day makes it easier for the nurse-social worker teams to become involved with performing these kinds of duties. As they become more responsible for performing them, they become less able to meet the requirements of the Initiative. This conflict over roles was reported to be the most significant barrier to implementing the CFST this past year.

Systems that seemed to handle this best did so through the use of management oversight from the Superintendent down to and including the principals in each school. Scotland, Martin, Hoke, Swain, Greene, Duplin, Pamlico, Vance, Person, Wayne, McDowell and Richmond are some of the counties where key personnel in their central offices have been empowered by the Superintendents to ensure that CFST nurses and social workers are not inappropriately burdened with duties that others in the schools could do. Across the state some individual principals have begun to facilitate weekly meetings of all their student support staff (counselors, nurses, social workers, attendance counselors, homeless coordinators, exceptional children directors, etc.) for the purpose of discussing the

students and deciding which school program is best suited to meet their needs. Even with this level of support, the nurses and social workers often find themselves pulled between performing traditional duties and doing their CFST work.

Some of the pull is the result of being easily accessible to their entire client base almost all of the time. By definition school nurses and school social workers are in the schools. This means that while they may have plans to make home visits, meet community partners for planning sessions, or enter data into the case management system; they also must answer the door whenever a student asks for assistance or a teacher sends one to them for any one of a number of reasons. While having principals support CFST roles may alleviate some of the problem, it does not resolve all of it. This is due to the fact that students have direct, unrestricted access to them most of the time. Some nurses and social workers have developed schedules for their office hours, data entry hours, and home visit hours as a way to address the issue. Others have developed flow charts to help staff understand what should and should not be referred to them. Those who have taken such actions report that they tend to work at times, but also fail at others depending on the circumstances.

Another barrier this past year was the difficulty of some to establish interagency communication and collaboration. As the Initiative is based upon collaboration, any barrier in this area would be significant. Some counties like Durham, Scotland and Alamance have deep ties to their local System of Care efforts and have tied the CFST collaboration into them. Others, like Caldwell and Nash have developed strong interagency collaboration through establishing regular meetings with agency partners to provide education and build relationships. Hyde County has combined its CFST Local Advisory Committee with its School Health Advisory Committee and Juvenile Crime Prevention Council to streamline communication and effectiveness. Halifax County has developed a schedule of regular meetings and invites staff from other agencies to attend, participate and provide in-service training for school staff. They also provide in-service training for other agencies in the community. Wayne and Forsyth counties utilize very strong, existing community collaborative committees and build on strong existing relations with the medical community to help them overcome any barriers concerning communication and work with other agencies.

The authorizing legislation mandated the identification of specific personnel in DSS and MH. These positions were put in place throughout the 2006-2007 school year. Once these positions were established and manned interagency cooperation and coordination usually became much easier.

Two school systems (Bertie and Hyde) continue to face barriers concerning the recruitment of nurses. Each has also faced the organizational barrier of losing key members of their senior central office staff. Bertie County has had turn over in its Superintendent position as well as the person functioning as their CFST coordinator. Hyde County lost their Director of Student Support (who also functioned as the CFST coordinator). A strength of Bertie County is that, even with the change in key positions, they have continued to work with the NC Division of Public Health school nurse

consultant to execute a contract with the East Carolina University School of Nursing for the provision of school nursing services. Hyde County has a plan to contract for a nurse through their public health department and should have one working full time as a CFST school nurse January 1, 2008.

One school system faced the barrier of having no history of school social work services prior to their participation in the CFST. Until Anson County received the funding for 5 teams they did not have a social worker in their system. Organizationally they had no experience in supervising social workers or providing them with organizational supports. To their credit they initiated contact with the staff of Richmond County Schools and asked for assistance in this matter. This past year they have spent time in Richmond County observing their system and have had Richmond's lead school social worker visit, mentor and consult with them. The CFST coordinator in Anson County (who also is the school system's lead nurse) attends all CFST regional and advisory committee meetings and is making every effort to learn school social work so that she can provide the best supervision possible.

PROGRAM EVALUATION AND SUPPORT

The authorizing legislation requires that an evaluation process be developed to "ensure the goals and objectives of this Initiative are achieved"[15]. The Center for Child and Family Policy (CCFP)[16] at Duke University was chosen to conduct the evaluation.[17] The Center houses the North Carolina Education Research Data Center http://www.childandfamilypolicy.duke.edu/ep/nceddatacenter/index.html which stores and analyzes student performance information for the North Carolina Department of Public Instruction (DPI). The Center is also evaluating other child and family team initiatives run by state and local agencies including the implementation of the Multiple Response System (MRS), the 'Improving Child Welfare Outcomes through Systems of Care' grant and the Durham Family Initiative.[18]

The evaluation seeks to provide all the information required by the legislation, and study change over time in key outcomes. A summary of information required by the legislation includes:

- The number of students referred to the CFST
- Demographic information on students served by the CFST
- A description of the services needed by and provided to students
- Information about students placed in out of home placements
- Information concerning the funds expended to implement the Initiative

[15] 2007 Appropriations Act, Section 10.9. (b) (4) e.
[16] For more information concerning the Center please see its web site at http://www.pubpol.duke.edu/centers/child/
[17] For more information concerning the evaluation see the evaluation web site at http://www.duke.edu/web/cfst-eval/index.html
[18] See http://www.childandfamilypolicy.duke.edu/evalsvcs/index.html. for more information.

- Information on how families and consumers are involved in all levels of decision making
- Any other information as required by the Council and
- Recommendations on needed improvements.

The Center is collecting child specific data required by the legislation through the use of a web based case management system. Initial results and findings are included throughout this report, but should be interpreted with caution. The data is inconsistent across school systems and individual schools. This is largely due to the newness of the case management system, its incremental roll out last year, inexperience of staff in both providing CFST services as well as entering data, and a misunderstanding by some staff of exactly what information needs to be entered.

It is anticipated that as this year progresses these issues will be less significant. The case management system is fully operational, staff has had one full year of experience in providing CFST services and entering data and a data entry manual has been developed to help the nurses and social workers understand and use the case management system.[19]

Child-level outcomes of interest include academic achievement (attendance, end of year math and reading scores, and disciplinary referrals) and out-of home-placement (placement in foster care and inpatient psychiatric facilities). The evaluation team has developed a protocol for linking the multiple data sets while protecting the confidentiality. They have also designed the case management system to capture all required information concerning students and the services they received while not allowing the information to be accessed in such a way that a user would be able to indentify a specific student.

Administrative datasets maintained by DPI, DSS and DJJDP provide longitudinal information on both children and schools from 2000 through the current year. DPI's administrative data from the 2006-2007 year school session has not yet been made available to the Center and therefore this report is unable to address any connection between provided services and academic outcomes. The same is true for the data available to support the success of the Initiative such as out of home placements and juvenile court connections. It will not be available until reported to the appropriate agencies (Division of Social Services and Department of Juvenile Justice and Delinquency Prevention), and the evaluation team from Duke University has had the opportunity to evaluate all information through the CFST Case Management System, use propensity scoring techniques to create a control group, and compare them with children who received services through the CFST Initiative. This vital information will be included in future legislative reports.

The Program Coordinator provides support to local staff connected to the Initiative in various ways. Some of them are:

[19] To see the manual please refer to "North Carolina's School-based Child and Family Support Team" at http://www.duke.edu/web/cfst-eval/practitioners/CFSTManual.pdf

- 5 regional meetings every other month
- A minimum of 2 site visits per school system per school year,
- 4 one-day regional training events for principles and school system senior managers prior to the beginning of the school year,
- Quarterly meetings with school system contacts and key state agency staff members
- Issue specific site visits and technical assistance as needed.

Existing data and information is promising but inconsistent. That inconsistency presents as the programmatic priority for the upcoming months. Responding to the need to define and enhance key issues and areas of practice will be the focus of efforts that include conducting environmental scans (with Duke University and all local stakeholders) and utilizing the regional meetings for joint learning and discussion. These issues include:

- How to define an appropriate referral and educating school staff on how to make them
- How to engage and partner with families
- How to organize and facilitate a CFST meeting, and
- How to best achieve interagency collaboration.

SUMMARY

As stated earlier, the mission of the CFST is for participating child serving State and local agencies to collaborate to provide individualized, strengths based, family centered support services at such a level that every child in their communities will be given every opportunity to succeed academically. This report has documented that the 21 school systems have begun to make promising progress towards achieving it. Approximately 7,600 students have received a variety of services, and the schools are engaging families and community partner at a greater level than they have in the past. As the school data is not available there is no current capacity to link this progress with actual academic outcomes. It is expected that this data will be available for the next report on July 1, 2008.

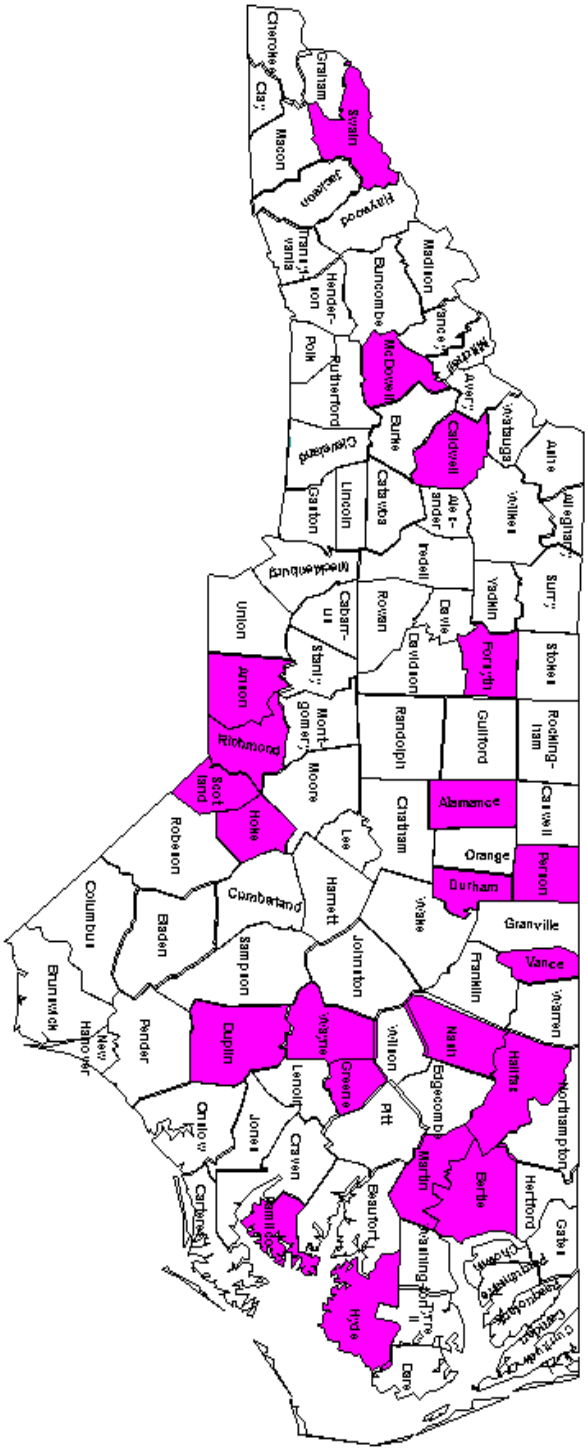
ATTACHMENTS

1) Map of School Based Child & Family Support Team Participating Local Education Agencies and Schools

2) List of Participating Local Education Agencies and Schools

3) North Carolina School Based Child and Family Support Team Interagency Connections

Attachment 1: Map of School Based Child & Family Support Team Participating Local Education Agencies and Schools



Attachment 2: School Based Child & Family Support Team Initiative Participating Local Education Agencies and Schools

LEAs and Schools		LEAs and Schools	
Alamance	• Cummings High • Broadview Middle • Andrews Elementary • Eastlawn Elementary • Harvey Newlin Elementary • Graham High • Graham Middle	Anson	• Anson High • Anson Middle • Morven Elementary • Wadesboro Elementary • Wadesboro Primary
Bertie	• West Bertie Elementary • Windsor Elementary • Bertie Middle • Bertie High	Caldwell	• Whitnel Elementary • West Lenoir Elementary • Gamewell Elementary • Gamewell Middle • West Caldwell High
Duplin	• James Kenan High • Rose Hill-Magnolia Elementary • Warsaw Elementary • Charity Middle • E.E. Smith Middle • Warsaw Middle	Durham	• Bethesda Elementary • Neal Middle • Southern High • Eastway Elementary • Y.E. Smith Elementary • Lowe's Grove Middle • Hillside High

Attachment 2: School Based Child & Family Support Team Initiative Participating Local Education Agencies and Schools

LEAs and Schools		LEAs and Schools	
Forsyth	• Konnoak Elementary • Philo Midle • Parkland High • Ibraham Elementary • Middle Fork Elementary • Walkertown Middle • Carver High	Greene (All schools in the county)	• Greene Central High • Greene County Middle • Snow Hill Primary • West Greene Elementary
Halifax	• Northwest Halifax High • Southeast Halifax High • William R. Davie Middle • Aurelian Springs Elementary	Hoke	• South Hoke Elementary • West Hoke Elementary • West Hoke Middle • Hoke County High
Hyde (2 teams for 3 campuses)	• Mattamuskeet Elementary • Mattamuskeet Middle • Mattamuskeet High	Martin	• E J Hayes Elementary • Williamston Middle • East End Elementary • Roanoke Middle
McDowell	• McDowell High • East McDowell Junior High • Nebo Elementary • Eastfield Elementary	Nash-Rocky Mount	• D.S. Johnson Elementary • Williford Elementary • Nash Central Middle • Nash Central High
Pamlico (All schools in the county)	• Fred Anderson Elementary • Pamlico County Middle • Pamlico County High • Pamlico County Primary	Person	• Northern Middle • Southern Middle • Person High

Attachment 2: School Based Child & Family Support Team Initiative Participating Local Education Agencies and Schools

LEAs and Schools		LEAs and Schools	
Richmond	• Rohanen Primary • Ashley Chapel Elementary • Hoffman Elementary • Ellerbe Junior High	Scotland	• Carver Middle • Sycamore Lane Middle • Laurel Hill Elementary • Wagram Primary • Spring Hill Middle • I.E. Johnson Elementary • North Laurinburg Elementary
Swain (All schools in the county)	• Swain High • Swain Middle • Swain East Elementary	Vance (All schools in the county)	• L.B. Yancey Elementary • Henderson Middle • Southern Vance High • Pinkston Street Elementary • Eaton-Johnson Middle • Northern Vance High
Wayne	• Spring Creek Elementary • Spring Creek High • North Drive Elementary • Brogden Primary • Grantham School • Carver Elementary		

Attachment 3: North Carolina School Based Child and Family Support Team Interagency Connection (effective 7/2007)

21 Local Education Agencies (LEA)	13 Local Management Entities (LME)	22 Departments of Social Services (* received state Facilitator funds)	22 Local Health Departments	18 Department of Juvenile Justice / Delinquency Prevention Judicial Districts
Alamance-Burlington	Alamance-Caswell-Rockingham LME	Alamance County DSS	Alamance County HD	15A
Winston-Salem/Forsyth	Centerpoint Human Services	Forsyth County DSS	Forsyth County HD	21
Durham	The Durham Center	Durham County DSS	Durham County HD	14
Duplin	Eastpointe	Duplin County DSS*	Duplin County HD	4
Wayne		Wayne County DSS	Wayne County HD	8
Halifax	Five County Mental Health Authority	Halifax County DSS*	Halifax County HD	6A
Vance		Vance County DSS*	Granville-Vance District HD	9
Caldwell	Foothills Area MH/DD/SAS Authority	Caldwell County DSS	Caldwell County HD	25
McDowell		McDowell County DSS*	Rutherford-Polk-McDowell District HD	29
Pamlico	East Carolina Behavioral Health	Pamlico County DSS*	Pamlico County HD	3B
Bertie		Bertie County DSS*	Albemarle District HD	6B
Person	Orange-Person-Chatham MH/DD/SAS Authority	Person County DSS	Person County HD	9A
Scotland	Southeastern Regional MH/DD/SAS Services	Scotland County DSS	Scotland County HD	16A
Hoke	Sandhills Center for MH/DD/SAS	Hoke County DSS*	Hoke County HD	
Anson		Anson County DSS*	Anson County HD	20
Richmond		Richmond County DSS	Richmond County HD	
Swain	Smoky Mountain Center	Swain County DSS	Swain County HD	30
Hyde	Albemarle Mental Health Center	Hyde County DSS*	Hyde County HD	2
Martin		Martin County DSS*	Martin-Tyrrell-Washington District HD	
Greene	The Beacon Center	Greene County DSS*	Greene County HD	8
Nash/Rocky Mount		Nash County DSS*	Nash County HD	7
		Edgecombe County DSS	Edgecombe County HD	